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TRICARE
MANAGEMENT
ACTIVITY

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MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Open Access Appointing

Open access (also known as advanced access) appointing is viewed by many as a revolution in the process of developing schedules and booking medical appointments. The basic premise of open access appointing is that beneficiaries will see providers on the same day that they request an appointment. Many Military Treatment Facilities (MTFs) in the Military Health System are contemplating adopting this appointing strategy. It must be understood that implementing open access requires a firm commitment from leadership, a great deal of planning, and significant up-front training for staff who schedule appointments. In an effort to ensure that this process remains standard, the TRICARE Management Activity's (TMA's) Appointment Standardization Integrated Program Team has published the attached guidance for MTFs to follow when implementing open access appointing. This information will also be included in the *Appointment Standardization Commander's Guide to Access Success*.

It is strongly recommended that facilities that are considering implementation of an open access appointing methodology perform extensive research and develop a sound business plan. MTFs will coordinate their intentions with their respective Lead Agent, Service Intermediate and Service Level Commands, and TMA's Regional Operations Directorate at least 60 days in advance of opening open access schedules. This advance notice and prior planning is to ensure that contractual, customer expectation, staffing and service integrity issues can be avoided and improve the chances of success for open access appointing at given sites.

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Thomas F. Carrato
Executive Director

Attachment:
As stated

cc: Lead Agents

Open Access Appointing

Foreword

This section of the *Commander's Guide to Access Success* will describe a new booking model titled Open Access (or Advanced Access). The section will cover the methods to use to book appointments using a standard methodology. The objective is for Military Treatment Facilities (MTF) who elect to implement Open Access to be able to measure patient access consistently and accurately and monitor success or failure up front. This section is not an endorsement of Open Access. Sites have had both good and marginal experiences implementing this model. But an attempt has been made here to openly present the experiences and feedback from the Open Access sites to help other MTFs as they contemplate whether this model will work in their environment. Case studies from facilities at Hill AFB, Utah and Ramstein AB, Germany, are included in Section VII of this appendix.

I. What is Open Access?

Open Access (also referred to as Advanced Access Appointing) is viewed by many as a revolution in the process of developing schedules and booking medical appointments for patients. The rule, "Do today's work today" is the foundation of Open Access appointing. Today means today, not within 24 hours. The basic principle and MHS goal in utilizing Open Access is that a patient will see a provider on the same day that they request an appointment. This does not mean that the clinic is opening itself as a full walk-in service. The underlying premise behind Open Access is that both patients and providers are better off if everyone in the clinic is able to do today's work today. This includes both seeing patients today, as well as completing all related administration and paperwork that flows into the clinic. Assurance of continuity of care, i.e., the patient will see their own physician, is an additional objective and a by-product when the model is properly executed.

Open Access is primarily used to book Primary Care appointments but may also be applied in Specialty Care clinics. It is patient-driven, with all preferences for appointment time being chosen by the patient. It is non-intuitive and cannot be adopted suddenly and without extensive study and research of utilization patterns and history on the part of the clinic that wishes to undertake this model. Due to its non-intuitive nature, regular and consistent training and re-training and re-emphasis of Open Access concepts and practices are necessary for clinical staff and providers. Otherwise backsliding into previous undesirable patterns and practices will most certainly occur. Open Access appears to improve staff and patient satisfaction in many but not all settings; its impact on improving physician/provider retention in the military is unknown.

In order to successfully implement the Open Access model, the physician's "bad" appointment backlog must be eliminated. "Bad backlog" represents appointments that have been made into the future and were built into an inventory as a result of common "carve-out" techniques used in many military treatment appointment schedules. Many of these types of appointments are of a routine or follow-up nature and could or should be

seen sooner rather than later. It is called "backlog" because this inventory of appointments results in a longer and more frustrating waiting time for the appointment on the part of the patient. "Good backlog" is generally acceptable and consists of appointments made by patients who request an appointment other than today because of convenience or preference expressed by the patient. An additional critical requirement and potential failure point is that clinics must be optimized to provide the necessary support staff to prevent burn out.

Open Access works best when it provides incentive to the system to do today's work today. Templates need to be arranged to ensure that a clinician is in the clinic at least some time each day. Alternatively, a clinician pair can split days and a panel. If a provider sees his/her own patients, the incentive is to do everything possible to complete all the work needed to care for that patient, including follow-up work. This only occurs when the provider is seeing their own patients i.e., ownership. If providers take care of all their own work today, on average each provider will see 20 patients a day, but a few days (on the far end of the bell shaped curve) some providers will see 30 patients and others will see 10 patients.

Open Access may allow Military Treatment Facilities (MTF) to re-examine the role of demand management programs. For example, nurse triage may become more valuable in determining WHO the patient should see (e.g., their PCM, a nurse, or a technician) rather than WHEN the patient should be seen.

The advantages of Open Access are the following:

- reduces the time-consuming need to prioritize or triage care
- enhances the patient's satisfaction and compliance by guaranteeing timely access to care
- improves quality by providing care close to the onset of the problem
- enhances the patient's trust of the system
- reduces the need for a patient to "game" the system by booking multiple appointments in an attempt to obtain a convenient appointment
- patients who know they have ready access are much more willing to do home-care for minor illnesses
- patient no-show and cancellation rates are decreased
- management of schedules is simplified in some ways but must be closely monitored and coordinated; often easier to modify schedules on short-notice
- may enhance continuity of care
- on days with decreased demand, clinical staff will have greater flexibility to accomplish other tasks/leave early

Disadvantages include:

- surges in demand may require that providers and support staff work extended hours
- staff burn out is possible
- requires frequent, possibly daily, schedule review and adjustment
- requires provider and staff buy-in

- frequent or seasonal staff turnover, deployments, etc., can cause access problems and significantly increase the workload for remaining staff
- significant and on-going training and planning required
- providers must be available to meet patients' needs in order to maintain continuity of care and "do today's work today"

II. How is Open Access Administered?

The Open Access model is based on research indicating that demand can be predicted and consistent over time for a practice or clinic. A clinic should begin by determining its true population and patient historical demand, and determining the level of effort required to eliminate the patient backlog and sustain Open Access. True demand is defined as a request for an appointment made either during or after normal business hours. This includes patients who were trying to be seen in the clinic, but had to settle for an emergency room visit because the clinic was closed. It also includes those patients whose request for an appointment was pushed back to a future date or deferred/handed off to another clinic or facility. This is a misleading simple measure as it can take quite some time to collect this kind of data. Without question, the clinic must ensure that they are appropriately staffed so they can see today's calls today most of the time. Many clinics that utilize Open Access have found that about 75% of appointments should be available for same-day demand. This may vary based on the population served, mobility activities, and other local conditions that must be factored into the equation.

Implementing Open Access requires a firm commitment from leadership, clinical and administrative staff, etc. to eliminate any existing backlog of patients. This often requires a "surge" effort involving overtime/extended hours clinics until the backlog is eliminated or, at the very least, to the point where providers are noticing on their own metrics that they are seeing their patients within a single day of the patient's request for an appointment. The likelihood of success is significantly diminished without strong buy-in from the clinic staff. In addition, implementation during periods of high demand (e.g., when there has been frequent staff turnover or during the flu season) has proven to be problematic.

Managing an Open Access clinic requires significant up-front training for staff who schedule appointments. Under Open Access, patients calling for an appointment today – whether for a routine or an acute problem – will be booked into the Open Access appointment type (OPAC), but will be classified differently in the Access To Care module of MCP. To manage an open access clinic, no distinction is made between routine and acute care for patients who call in today, unless the visit requires resources that are not present every day (e.g. specific personnel, equipment, etc). Follow-up care should be avoided if possible so that ALL the patient's issues are addressed in a single visit in order to eliminate the need to add future appointments/repeat visits for the same patient. These booked repeat visits are what add stress to the system and backlogs of appointments. Required follow-up care should be estimated and schedules should contain sufficient open appointments in the future to meet the need for follow-up visits or

patients who desire to schedule an appointment in the future for personal reasons. The clinic at Hill AFB has implemented a split of 70% open access and 30% follow-up appointments in the Primary Care schedules. Patients should have the option of scheduling known follow-up visits prior to leaving the clinic in order to reduce telephone workload in the future.

Template and real-time schedule management are essential. If necessary, additional appointments may need to be added to meet demand, or unused follow-up appointments may need to be transitioned to an Open Access appointment. Open Access appointment schedules will use only two standard appointment types: the new Open Access (OPAC) appointment type and the Established (EST) appointment type to reserve slots for good backlog. Appointments for Procedures (PROC) and Wellness (WELL) for annual GYN exams may also be needed.

Schedules should be carefully monitored to ensure that booked appointments are not overtaking the number of appointments designated as open. An excellent instrument is the MTF Template Analysis Tool that can easily show how the MTF is utilizing its capacity for appointments. This tool will also show the number of unused appointments on a daily basis. The MTF clinic can use this data as a forecasting tool to determine and manage its capacity for open appointments and whether or not they will be filled for any given day. In addition, sites may use the Cross Book (CB) detail code to reserve appointments for a particular PCM for TRICARE Prime patients who are enrolled to another PCM in the event that the patient's PCM is not available when they call or when the patient wishes to be seen. All other appointments are for the PCM's TRICARE Prime enrollees in support of continuity of care. Appointments other than the Open Access appointments (OPAC) should be corrected when booking the appointment to reflect the type of care scheduled for the patient so that sites can assess access to care. Some sites are freezing all future Open Access appointments (other than today's appointments) to prevent these appointments from being booked in advance of today.

Since demand is not always consistent, the clinic must have a contingency plan that will kick-in when demand surges on specific days and under unpredictable conditions. A contingency plan may mean that the staff work later hours that day, staff members help other staff members, and roles of support staff are expanded to reduce non-care tasks for physicians. The rules must be clearly defined to the staff and management. A plan for "weaning" providers on and off their schedules during leave and temporary absence/duty periods is essential as is providing a plan for providers to agree on how their individual panel loads will be handled when the primary PCM is unavailable. Each clinic or team must establish criteria for provider absence from patient care duties, determine minimum number of providers on duty, and assign executive agent to control templates. Plans must be in place to increase supply capacity at select times (school physicals, etc) and time-off policy based on demand. The average number of appointment requests may vary daily or seasonally. The number of requests is usually greater on Mondays and Fridays, after a three-day holiday, and in the winter. Define the meaning of "Today", i.e., today, not within 24 hours. Morning huddles are a good idea to review the day and develop coordinated tactics.

Maintenance of provider panel sizes to manageable levels is critical. The military suggests a maximum of 1,500 enrollees per Primary Care Manager (PCM). Under Open Access, civilian guidelines suggest a capacity as low as 800 and as high as 2500 enrollees per PCM (refer to authors Murray and Tantau on Open Access). There is no absolute numerical key to the proper PCM to panel ratio. Open Access success has less to do with empirical figures than with the assurance that a PCM is consistently available to handle the patient demand. Most failures occur when demand for appointments is undermined by the loss of a patient provider for extended periods of time, the burden of the panel has to be taken up unexpectedly by another provider, and nursing and support staff becomes unduly stressed. Proper coordination and planning for provider absences allow for flexibility and response to the patient's requirements.

Lastly, Primary Care Manager By Name (PCMBN) is the most essential ingredient to the success of an Open Access method of appointing. A patient-provider relationship that is developed through PCMBN cultivates trust and long-term knowledge and familiarity with each individual patient's case. While this may be self-evident, it works with Open Access. Many unnecessary repeat and follow up visits that clog access and add to multiple-provider backlog are avoided when the PCM is regularly seeing his or her own enrollees and is not absent for extended periods of time. This phenomenon is known as "Percentage of Continuity" and must also be regularly measured.

These concepts are interlocking and must be equally considered and implemented. It must also be stressed that there is no "cookie-cutter" approach and that each clinic must adapt and customize practices based on the clinic's own features and services.

III. Appointment Standardization Business Rules for Open Access

MTFs that elect to implement Open Access should adhere to the following business rules.

- Each site that is contemplating a move to the Open Access appointing methodology will perform extensive research and should develop a business plan. Sites will assess their capacities, provider availability, true demand, provider-patient continuity, wait times for appointments tracked over time, and office flow patterns with any predictable surges and troughs.
- Sites will coordinate their intentions with their respective Lead Agent and Service Intermediate and Service Level Command at least 60 days in advance of opening Open Access schedules. Sites should be prepared to brief their capacity and ability to successfully undertake Open Access. This coordination will give these organizations time to provide needed funding, resources, support, and oversight. Contractual, customer expectation, staffing and service integrity problems can be avoided with advance notice and prior planning. This will improve the chances of success for Open Access appointing at given sites.

- Beneficiaries should not be informed of the new practices until a reasonable success rate and transition period have been established and proven. Historical evidence has shown that premature marketing and advertising serves only to confuse beneficiaries or engender high or unreasonable expectations. All activities during the transition period should be invisible to the beneficiary who should only notice that their ability to get an appointment has greatly improved.
- Upon notification from the candidate site, the Lead Agent will inform the TMA Access Project Manager, Regional Operations Division. The Lead Agent will address any necessary changes to existing Regional Agreements/Memorandums of Understanding before implementation can proceed.
- The Lead Agent, in collaboration with TMA, will coordinate Managed Care Support Contract changes and other administrative changes to ensure smooth implementation and a coordinated schedule.
- Open Access appointments will be indicated in schedules and templates with a new appointment type, OPAC. The access standard will be 24 hours, but is actually today. The Access to Care category will be Acute. The definition of this appointment type and a scenario are listed in Section IV below.
- If clinics elect to use other appointment types, they should use the appropriate standard appointment types and the applicable Access To Care categories for each appointment type as defined in the standard appointment type definitions in the *Commander's Guide to Access Success*, i.e., ACUT, EST, SPEC, WELL, PROC, and GRP. The *Commander's Guide to Access Success* is found on the TMA Access Imperatives web page at <http://www.tma.osd.mil/tai>.
- Sites have a new optional feature to help with Open Access continuity of care, a new Detail Code titled Cross Book (CB). Use of the CB detail code is not mandatory but, when used, will limit the appointments in a PCM or PCM Group schedule to TRICARE enrollees who could not obtain care with their own PCM or MTF. If a candidate site wishes to use the CB detail code, its use will be discussed in their business plans prior to opening schedules for open access booking and they will inform the Services, Lead Agents, and MCSC. This is to ensure there are no contract issues. CB may be used for other than Open Access appointments.
- Inform patients that they are being booked into Open Access and how it works. It has been recommended that the term Open Access not be used in marketing to patients as they may interpret this term as walk-in access without an appointment. Sites may want to come up with their own catch phrases such as advanced or enhanced access.
- TMA is working on several reports that will appear on the TRICARE Operations Center (TOC) web page to measure access to care for Open Access and other types of appointments.
- MTFs will develop and share ad hoc reports to assess the performance of Open Access.

IV. OPAC - Open Access Appointment Type Definition and Scenario

Definition: The OPAC appointment type is designated for patients who require a routine or acute office visit with their Primary Care Manager (PCM) or a specialist who call in today. Some sites may wish to include wellness appointments. Every effort will be made to allow patients to see their own physician on the same day that they request an appointment, but the clinic does not open itself into a full walk-in type service. The Open Access appointment is **not** an acute, routine, or follow-up type appointment. Follow-up care should be avoided if possible so that ALL the patient's issues are addressed in a single visit so as to eliminate the need to add future appointments/repeat visits for the same patient. Patients may be routed through Nurse Triage, if available, before the OPAC appointment is booked. The Nurse Triage can offer other appropriate alternatives for care such as self-care. In those locations where Nurse Triage is not in place, the concept of "prudent lay-person terminology" will be used in determining whether the patient can wait for a scheduled OPAC appointment or told to report immediately for acute service. OPAC appointment types will only be used in clinics at MTFs that have coordinated their use prior to establishing an open/advanced access appointing process with their Lead Agent and Service Commands.

The OPAC appointment type will use a 24-hour Access To Care standard and map to the Acute ATC category. However the appointment should always be booked the day of the patient request.

Scenario: Mrs. Snuffy has been experiencing a pain in her shoulder joint area for a couple of days and calls the 1-800 TRICARE Appointment Line on Monday morning to schedule a visit with her Primary Care Manager. The appointment clerk, at an Open Access MTF, in accordance with local guidelines or scripts determines the patient's needs and reaches the decision point to transfer Mrs. Snuffy's call to the Triage Nurse. The Triage Nurse, using approved protocols, rules out self-care and determines that an open access appointment is necessary. Mrs. Snuffy is told that appointments are available at several times Monday afternoon. Mrs. Snuffy chooses an appointment time of 1400 and, using the Order of Precedence for Appointments Search business rule, the Triage Nurse books the OPAC appointment and gives Mrs. Snuffy appropriate instruction.

V. Performance Measures for Open Access

The following reports are required to establish baseline performance and then track the progress of all of these measures. CHCS provides useful data that can be used.

1. *Appointment Availability*

There must be an adequate number of providers and support staff to provide health services. The fundamental delay that Open Access seeks to remove from clinic operations is the delay to the next available appointment. This is the single most important measure of progress and success. Check on a regular basis in CHCS for the third next available appointment for each

clinician participating in Open Access. Pick a routine appointment type, with a reasonable volume of services that tends to be the least available, i.e., a well-baby or a routine physical appointment. Use the third available appointment for each PCM and for the clinic as a whole. Better to measure from the patient perspective, including weekends. This means counting Saturday and Sunday in the delay.

Data tracked by TMA (<http://www.tricare.osd.mil/tools/Tat/TOC/TAT.htm>) provide a different view of appointment availability. For purposes of Open Access, the view of future appointment availability provided by the MTF Template Analysis Tool indicates how much future capacity is available each day to accommodate new patients. The more un-booked capacity the clinic has, the easier it will be to offer same-day services to patients who call that day.

Based on data extracted from CHCS, reports can show the average delay between the date of booking and the date of the appointment. Although some appointments booked are “good backlog” as they meet a patient's needs with other than a same-day appointment, the average over time is a good indicator of progress toward Open Access.

2. *Demand*

True demand is the total number of patients seeking services—patients who call the clinic for advice, those who unsuccessfully seek service, and patients who obtained appointments (the sum of all requests to your MTF for care). To measure demand requires examining booked appointments and patient services delivered each day, to obtain a reflection of what our work would look like if we did today's work today. This measurement should include those patients that tried to access the system but failed in some way (e.g., hung up, disconnected, left without being seen, etc.). However, many facilities do not have the capabilities to monitor telephone calls for missed access, so measuring demand can be determined by using the following measures in CHCS. CHCS captures appointment booking activity each day and non-appointed or overflow work (walk-ins, Urgent Care, possibly ED visits), making it relatively easy to obtain these totals. The sum of these totals is the true demand for the day. Examine demand by the patients for each provider, for each day over two weeks to get a baseline, and then each month to detect changes (ideally reductions).

3. *Continuity* (appointment is with PCM)

Examine continuity from the patient perspective (how often patients assigned to PCMs actually see their PCM when they come in for care) rather than from the provider perspective (how many of the patients each provider sees are on the provider's panel).

4. *Panel Size*

An important element of keeping supply and demand in balance is equalizing panel sizes, combined with other efforts to make providers accountable for managing their panel.

5. *Productivity*

A combination of improved office efficiency, changes in clinic schedules, and reduced no-shows can improve provider productivity. This metric is also of interest to Open Access to see the potential impact of improved operations on this important indicator of capacity.

6. *No-Shows*

In sites that have implemented Open Access, the percentage of patients who fail to show up ("No-Shows") for scheduled appointments dropped significantly. The metric is of interest because no-shows represent a misuse of supply. No-show data are obtained fairly easily from the CHCS.

7. *Cycle Times*

Cycle times measure the amount of time a patient spends receiving care from arrival to departure. Shortening of cycle times is a good indicator of improvements in office efficiency, both patient flow and workflow, which in turn improve capacity. CHCS does not currently collect this data so these metrics will have to be determined locally.

8. *Satisfaction Measures*

Measuring satisfaction of patients and staff before and after implementation of any new process is key to showing success or failure of the process. The underlying premise behind Open Access is that both patients and providers are better off if everyone in the clinic is able to do today's work today. This includes both seeing patients today, as well as completing all related administration and paperwork that flows into the clinic.

- a. *Patient Satisfaction* Has patient satisfaction increased? How do patients feel about having the option of an appointment on the same day they call the office? Do they feel that they are getting better quality, more timely care? Ask patients the above questions when they call to schedule an appointment, or give them a quick survey to complete in the reception area. Refer to existing patient satisfaction surveys collected by the MTF. These are either by episode or annual overall collected by TRICARE.
- b. *Staff Satisfaction* Are the staff and physicians more satisfied? Do providers get to see their own patients more often? Do providers feel their patients are getting more timely treatment? Do providers and staff feel that patients are more satisfied? Do providers and staff get time-off when they request it? Do they get to go home when the clinic closes, or do they have to stay late to do paper work?

VI. Some Recommended Steps to Implement Open Access

Step Nbr	Open Access Implementation Step	Completion Date	POC
1	Define MTF Commitments		
1a	Determine patient population		
1b	Determine patient demand for care (See Section II, paragraph one, and Section III above for guidelines)		
1c	Perform optimization/efficiency analysis to determine proper use of clinical staff such as the use of non-physician staff in place of providers for work that is neither related to patient care nor administrative in nature.		
1d	Plan and implement above efficiencies		
1e	Develop a business plan to book patients to meet the continuity of care goal that patients will be booked to their own PCM as close to 70% of the time as possible for continuity.		
1f	Assess appointment system capability for increase in same day appointing and medical records processing		
2	Determine staffing required		
2a	Implement new staffing responsibilities		
2b	Assure adequate staffing to support open access		
2c	Determine impact on medical records and appointments services		
3	Sixty days prior to implementation, sites will coordinate Open Access implementation with the Lead Agent and their Service Intermediate Command.		
4	The Lead Agent will coordinate implementation with the Managed Care Support Contractor (MCSC) (if they book appointments for the site) and ensure Regional Agreements/MOUs are updated as needed.		
5	The Service representative and Lead Agent will inform the TMA Access Project Manager, Regional Operations Division, that the site is implementing Open Access.		

Step Nbr	Open Access Implementation Step	Completion Date	POC
6	The Lead Agent in collaboration with TMA will coordinate contract changes and other administrative changes to ensure smooth implementation and a coordinated schedule.		
7	Sites must inform the Services, Lead Agents, and MCSC if they plan to implement the Cross Book (CB) detail code to support continuity of care and ensure that PCM appointments are available to enrollees when the patient's PCM is not available.		
8	If using the Cross Book detail code (CB), booking staff must be trained to understand that the CB detail code may be used to set aside appointments for patients who are unable to get care with their own PCM or at their MTF. By default (and this is a training issue), PCM or PCM Group enrollees will have priority for appointments without the CB detail code.		
9	The TRICARE Contractor will be instructed to book into the first available appointment.		
10	Develop a plan to reduce patient appointment backlog.		
11	Publish instructions to the staff documenting procedures, responsibilities, and schedules to reduce the backlog.		
12	Set up templates and schedules for Primary Care using the OPAC appointment type to indicate Open Access appointments. This is the only appointment type that should be used for Open Access appointments and will cover at a minimum routine and acute appointments booked the same day. Select the Routine Access to Care Category. Note this is for building the template, not when scheduling the appointment.		
13	In Open Access clinics, use EST for those appointments that will not be booked as Open Access appointments, i.e. the good backlog.		
14	Sites may freeze OPAC appointments so those appointments cannot be booked in advance, then release them within 24 hours of the appointment. However, sites must be careful to coordinate any template management programs with existing guidance if participating in other appointing initiatives such as TRICARE On-Line patient web booking.		

Step Nbr	Open Access Implementation Step	Completion Date	POC
15	In clinics that are not Open Access, use the standard appointment types per Appointment Standardization guidelines. These appointment types will be used to track access to care (ATC) at the clinic and should match the ATC category.		
16	If an Open Access appointment (OPAC appointment type) is used for other than Open Access appointments then it is recommended that sites change the appointment type to the appropriate standard appointment type, e.g., ROUT, WELL, EST, or PROC, either when booking the appointment or during End of Day (EOD) processing. This will allow sites to track their access to care using the Access to Care Summary Report in CHCS. For sites using only EST, PROC, and OPAC, this may not be necessary.		
17	Arrange for delivery of medical records to the clinic.		
18	PCM or provider directed follow-up appointments should be arranged before the patient leaves the clinic.		
19	Monitor schedules daily. If EST or WELL appointments will expire soon without being booked, change the appointment to an Open Access appointment in the schedule only if needed.		
20	Sites will define and implement metrics to measure the ongoing progress and status of Open Access including:		
20a	Ad hoc reports tracking Open Access Appointments and the average days for patients to get an appointment for the OPAC appointment type.		
21	After a careful transition period, the site will declare itself an Open Access site and inform the patients. Sites may want to use a different project title than "Open Access" as the patient may interpret Open Access as open walk-in .		

VII. Examples of Open Access Implementation in the Military Health System

The following two MTFs have implemented their own version of the Open Access appointing model in a Primary Care setting: Hill Air Force Base in Utah (TRICARE Central) and Ramstein AB in Germany (TRICARE Europe). The processes

and lessons learned from each model are described below. As many as 15 or 16 sites have tried and several have succeeded in implementing Open Access.

Open Access at Hill Air Force Base, Utah (clinic, not a bedded facility)

Analysis: Hill determined that 75% of its Primary Care calls are same day demand and up to 1.5% of all enrollees request an appointment each day. A Primary Care patient will seek care an average of four times per year.

Hill graphed the monthly demand for appointments. The graph showed that the patient population fluctuated up and down by 100 to 200 patients from month to month and increased 621 over a year from 16,200 to 17,500. Hill also consulted and used the civilian utilization rates of 800-2,500 patients per Primary Care provider.

Enrollee demand for Primary Care fluctuated up and down by 100 to 400 appointments per month and actually dropped approximately 800 appointments per month when Open Access was implemented in June 2001. Under Open Access, the reduced level was sustained throughout 2001.

Staffing: Hill created two pods with five teams each in Family Practice and three teams in Pediatrics. Each team consists of one provider (either a physician assistant, nurse practitioner, or physician), one administrative technician, two medical technicians, and one nurse. Support staff members are used to provide extended care. One person per clinic (Family Practice, Pediatrics, and Flight Medicine) is on-call during off-duty hours to authorize emergency room visits.

Templates and Schedules: Hill implemented template and schedule management for Open Access. Appointments were either same day (an ACUT appointment type) or not same day (EST appointment type). All appointment lengths were 15 minutes and could be overbooked with every fourth of the hour left blank. For the majority of the providers, the last appointment of the day is at 1500 but the clinic remains open until 1900. PCMs are scheduled to spend an average of 70% (and as high as 76%) of their time physically in the clinic. Hill created schedules for technicians in order to manage their time and is in the process of linking technician and provider schedules in order to enhance team efficiency.

Hill is working with the Appointment Standardization IPT to define the Hill templates and schedules to conform to the new Appointment Standardization guidelines.

Booking: Open Access is implemented in Primary Care, Flight Medicine, and Pediatrics. ACUT appointments are bookable only on the day of the appointment. Urgent care for the next day must be booked into EST appointments. PCM\$ is used for Right Start (newly arrived personnel) appointments. ACUT\$ is used for sick call appointments and are frozen then released (as are ACUT appointments). Walk-in appointments are assigned when demand exceeds capacity. Patients may cross book to other PCM teams if their PCM is unavailable. They are testing a new schedule in which

patients are double booked on the half-hour so one patient can be prepped while the other is being treated.

Successes: Under Open Access, the average total wait time for all ATC categories at Hill is 3.5 days; the Open Access wait time is 1.19 days. Hill meets the access standard for 99.4% of all access to care categories and 98.17% of the routine standard. Network and Emergency Room Utilization have decreased. No-Shows are down to 4.39% from 5.98%. Hill continues to book some appointments in the future and is implementing a patient reminder system to be implemented in February 2002. In October 2001 Hill had 28.6 Relative Value Units (RVU) per PCM per day, up from 18.3. These are weighted average workload tied to Evaluation and Management (E&M) codes. Patients see their PCM By Name 57 % of the time, up from 44%. PCMs are spending 76% of their time in their Primary Care clinic, up from 61%. Most providers are very happy; technicians are not completely satisfied. Hill seems to be recapturing the civilian work.

Advanced Access at Ramstein Air Base, Germany (clinic, not a bedded facility)

Analysis: Ramstein has 21,000 enrollees with no contractor booking. Advanced Access was first implemented in the spring of 2001 in Family Practice, Pediatrics, Flight Medicine, and Sembach Family Practice – a total of 15 equivalent PCMs (Flight Medicine PCMs equal 0.5).

Staffing: Ramstein follows the AF Primary Care Optimization (PCO) Model with four support staff for every PCM. Providers and staff are grouped in teams of three with each functioning as its own clinic. Staffing and coordination are all managed within this team. Each PCM has 1,400-1,500 enrollees.

Early in the summer, clinics were faced with drastic provider underlaps due to PCS and separation. Family Practice, the largest clinic, experienced 55% staffing in providers for several months. True advanced access as implemented in the civilian sector requires a stable medical treatment team who are available for patient care 5-6 days every week. The only exceptions would be planned vacations and educational leaves.

Templates and Schedules: Templates and schedules for each provider use the standard appointment types. Same day (ACUT) are 60% of appointments, not same day (ROUT) are 16-30% of seven day future booking, and a minimum of two WELL appointments are set aside for preventive health care. Ramstein allows SPEC, PROC, EST, PCM, and GRP appointment types as needed on rare occasions. To allow for flexible booking, templates and schedules are not specifically carved out for special types of care. One slot per day is carved out for pay patients and retirees but only if the manning level is above 49%.

Booking: Patients are booked the same day they call. If the patient wants a different day, he/she is booked for that day and that appointment is considered good backlog. If the schedule is full, the PCO team will work the patient in the same day with

nurse oversight. Patients will be cross-booked to a different PCM only if their PCM is absent from duty (e.g., TDY, leave, or deployed). In this case appointment clerks look to the other two PCMs within the team of three providers. If there are no appointments within the team of three, the patient will be worked in with nurse oversight. If the patient is seen the day of the call, there is no need to assess whether the required care is urgent. The booking staff selects the appropriate Access to Care Category that most closely meets the type of care required by the patient, i.e. acute, routine, wellness. However, the appointment type is not changed (i.e., a patient with a routine need will be booked into an ACUT appointment with the Access to Care category classified as routine).

Treatment: In the early implementation, providers were asked to maximize every patient visit. They were instructed to take care of all patient problems within means. The theory was based on reducing backlog. If all patient problems could be resolved today then the patient would not need to call back for an appointment in a week or two. Thus, a future visit would be freed up. This resulted in very long cycle times and waits past patient's set appointment time. This philosophy has been abandoned

Results: The TRICARE Europe website has been used to track performance.

- Same-Day Bookings: Clinics have seen an increase from 47% in Jan 01 to 62% in Dec 01
- Average wait in days for all appointments: Decreased slightly from 5.83 in Jan 01 to 4.37 in Dec 01. The small decrease could be attributable to other factors besides Advanced Access.
- Booking Demand (number of visits): No significant change – averaged approximately 7,000 per month entire year of 2001 with minimal variance.
- Continuity of Care (patient visit with assigned PCM): above 70% from Oct 01 to Dec 01 - one of the best in all of Europe. Ramstein has implemented an aggressive policy for continuity and results are not necessarily related to Advanced Access
- No-Shows: No significant change – fairly constant across 2001 at 6%
- Patient Cycle Time: The amount of time a patient spent receiving care from arrival to departure increased significantly during implementation, but has returned to previous levels after abandoning the “do everything in one visit” philosophy as stated above.
- Satisfaction measures: No significant findings have been found concerning the satisfaction from the patient population in relation to this program. Staff satisfaction has not been good – more detail below in Lessons Learned.

Lessons Learned: Provider buy-in is the single most important factor in the implementation of any Advanced Access model. This program did not receive a very good welcome at Ramstein due to a large provider PCS turnover shortly after implementation. Morale was very low and many blamed Advanced Access. Providers and staff are still not convinced it is any better than the previous system. There is no process guarantee that a provider underlap will not occur again.

The second critical factor of an Advanced Access model is staffing, especially during implementation. In order to reduce “backlog,” providers and staff are required to work extended hours. With less than 100% provider staffing, workload is shifted to the other providers on top of reducing backlog.

Reducing backlog is a major hurdle to overcome. It would not be so bad if it could be worked down once and then forgotten. In practice backlog creeps back up with every provider absence and has to be worked down each time in order to maintain the designed benefits of Advanced Access.

Advanced Access has not achieved all of the desired outcomes at the Ramstein Clinic. Minor improvements have been experienced in most areas with excellent results in continuity of care, however none of which are necessarily related to Advanced Access. Questions remain with this program in relation to TRICARE Online web-based appointments. The two programs directly conflict with one selling same-day appointments and the other advertising appointments whenever the patient requests.

We may not be able to emulate the civilian model in the military setting due to the requirements for readiness, support staff training and frequent loss of personnel without immediate replacements. Although Advanced Access has many benefits, and a modified form might work in the military setting, we would hesitate to recommend it Air Force wide without further pilot study and modifications to fit the needs of the Air Force Medical Service.